Senate

General Assembly

File No. 200

January Session, 2015

Substitute Senate Bill No. 860

Senate, March 24, 2015

The Committee on Aging reported through SEN. FLEXER of the 29th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING PRESUMPTIVE MEDICAID ELIGIBILITY FOR HOME CARE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-342 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) The Commissioner of Social Services shall administer the Connecticut home-care program for the elderly state-wide in order to prevent the institutionalization of elderly persons who (1) **[**who**]** are recipients of medical assistance, (2) **[**who**]** are eligible for such assistance, (3) **[**who**]** would be eligible for medical assistance if residing in a nursing facility, or (4) **[**who**]** meet the criteria for the state-funded portion of the program under subsection **[**(i)**]** (j) of this section. For purposes of this section, a long-term care facility is a facility that has been federally certified as a skilled nursing facility or intermediate care facility. The commissioner shall make any revisions in the state Medicaid plan required by Title XIX of the Social Security Act prior to implementing the program. The program shall be structured so that

the net cost to the state for long-term facility care in combination with the services under the program shall not exceed the net cost the state would have incurred without the program. The commissioner shall investigate the possibility of receiving federal funds for the program and shall apply for any necessary federal waivers. A recipient of services under the program, and the estate and legally liable relatives of the recipient, shall be responsible for reimbursement to the state for such services to the same extent required of a recipient of assistance under the state supplement program, medical assistance program, temporary family assistance program or supplemental nutrition assistance program. Only a United States citizen or a noncitizen who meets the citizenship requirements for eligibility under the Medicaid program shall be eligible for home-care services under this section, except a qualified alien, as defined in Section 431 of Public Law 104-193, admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for services under this section prior to July 1, 1997, shall remain eligible for such services. Qualified aliens or other lawfully residing immigrant aliens not determined eligible prior to July 1, 1997, shall be eligible for services under this section subsequent to six months from establishing residency. Notwithstanding the provisions of this subsection, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has intellectual disability shall be eligible for assistance pursuant to this section. Qualified aliens, as defined in Section 431 of Public Law 104-193, or other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for services under this section provided other conditions of eligibility are met.

(b) The commissioner shall solicit bids through a competitive process and shall contract with an access agency, approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined by regulations adopted pursuant to subsection **[**(e)**]** (n) of this section, that submits proposals **[**which**]** that meet or exceed the minimum bid

requirements. In addition to such contracts, the commissioner may use department staff to provide screening, coordination, assessment and monitoring functions for the program.

(c) The community-based services covered under the program shall include, but not be limited to, **[**the following**]** services **[**to the extent that they**]** that are not available under the state Medicaid plan, such as occupational therapy, homemaker services, companion services, meals on wheels, adult day care, transportation, mental health counseling, care management, elderly foster care, minor home modifications and assisted living services provided in state-funded congregate housing and in other assisted living pilot or demonstration projects established under state law. Personal care assistance services shall be covered under the program to the extent that (1) such services are not available under the Medicaid state plan and are more cost effective on an individual client basis than existing services covered under such plan, and (2) the provision of such services is approved by the federal government. Recipients of state-funded services, pursuant to subsection (j) of this section, and persons who are determined to be functionally eligible for community-based services who have an application for medical assistance pending, or are determined to be presumptively eligible for Medicaid pursuant to subsection (e) of this section, shall have the cost of home health and community-based services covered by the program, provided they comply with all medical assistance application requirements. Access agencies shall not use department funds to purchase community-based services or home health services from themselves or any related parties.

(d) Physicians, hospitals, long-term care facilities and other licensed health care facilities may disclose, and, as a condition of eligibility for the program, elderly persons, their guardians, and relatives shall disclose, upon request from the Department of Social Services, such financial, social and medical information as may be necessary to enable the department or any agency administering the program on behalf of the department to provide services under the program. Long-term care facilities shall supply the Department of Social Services with the names

and addresses of all applicants for admission. Any information provided pursuant to this subsection shall be confidential and shall not be disclosed by the department or administering agency.

[(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to define "access agency", to implement and administer the program, to establish uniform state-wide standards for the program and a uniform assessment tool for use in the screening process and to specify conditions of eligibility.**]**

(e) Not later than October 1, 2015, the Commissioner of Social Services shall establish a system under which the state shall fund services under the Connecticut home-care program for the elderly for a period of up to ninety days for applicants who require a skilled level of nursing care and who are determined to be presumptively eligible for Medicaid coverage. The system shall include, but not be limited to: (1) The development of a preliminary screening tool by the Department of Social Services to be used by representatives of the access agency selected pursuant to subsection (b) of this section to determine whether an applicant is functionally able to live at home or in a community setting and is likely to be financially eligible for Medicaid; (2) authorization by the commissioner for such access agency representatives to initiate home-care services not later than five days after such functional eligibility determination for applicants deemed likely to be eligible for Medicaid; (3) a presumptive financial Medicaid eligibility determination for such applicants by the department not later than four days after the functional eligibility determination; and (4) a written agreement to be signed by such applicant attesting to the accuracy of financial and other information such applicant provides and acknowledging that (A) state-funded services shall be provided not later than ninety days after the date on which home-care services begin, and (B) such applicant is required to complete a Medicaid application on the date such applicant is screened for functional eligibility or not later than ten days after such screening. The department shall make a final determination as to Medicaid eligibility for persons determined to be presumptively eligible for Medicaid

coverage not later than forty-five days after the date of receipt of a completed Medicaid application from such applicant.

(f) To the extent permissible under federal law, the Commissioner of Social Services shall retroactively apply a final determination of Medicaid eligibility for persons determined to be presumptively eligible for Medicaid coverage for a period not to exceed ninety days before such person's Medicaid application was completed.

[(f)**]** (g) The commissioner may require long-term care facilities to inform applicants **[**for admission**]** of the Connecticut home-care program for the elderly established under this section and to distribute such forms as the commissioner prescribes for the program. Such forms shall be supplied by and be returnable to the department.

[(g)**]** (h) The commissioner shall report annually, by June first, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to human services on the Connecticut home-care program for the elderly in such detail, depth and scope as said committee requires to evaluate the effect of the program on the state and program participants. Such report shall include information on (1) the number of persons diverted from placement in a long-term care facility as a result of the program, (2) the number of persons screened **[**, (3)**]** for the program, (3) the number of persons determined presumptively eligible for Medicaid, (4) savings for the state based on institutional care costs that were averted for persons determined to be presumptively eligible for Medicaid who later were determined to be eligible for Medicaid, (5) the number of persons determined presumptively eligible for Medicaid who later were determined not to be eligible for Medicaid and costs to the state to provide such persons with home care services before the final Medicaid eligibility determination, (6) the average cost per person in the program, **[**(4)**]** (7) the administration costs, **[**(5)**]** (8) the estimated savings to provide home care versus institutional care for all persons in the program, and **[**(6)**]** (9) a comparison between costs under the different contracts.

[(h)**]** (i) An individual who is otherwise eligible for services pursuant to this section shall, as a condition of participation in the program, apply for medical assistance benefits **[**pursuant to section 17b-260**]** when requested to do so by the department and shall accept such benefits if determined eligible.

[(i)**]** (j) (1) On and after July 1, 1992, the Commissioner of Social Services shall, within available appropriations, administer a state-funded portion of the Connecticut home-care program for the elderly for persons (A) who are sixty-five years of age and older and are not eligible for Medicaid; (B) who are inappropriately institutionalized or at risk of inappropriate institutionalization; (C) whose income is less than or equal to the amount allowed **[**under subdivision (3) of subsection (a) of this section**]** for a person who would be eligible for medical assistance if residing in a nursing facility; and (D) whose assets, **[**if single, do not exceed the minimum community spouse protected amount pursuant to Section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed one hundred fifty per cent of said community spouse protected amount and on and after April 1, 2007, whose assets,**]** if single, do not exceed one hundred fifty per cent of the minimum community spouse **[**protected amount**]** resource allowance pursuant to **[**Section 4022.05 of**]** 42 USC 1396r-5(f)(2) as set forth in the department's uniform policy manual or, if married, the couple's assets do not exceed two hundred per cent of said community spouse protected amount.

(2) Except for persons residing in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e, as provided in subdivision (3) of this subsection, any person whose income is at or below two hundred per cent of the federal poverty level and who is ineligible for Medicaid shall contribute seven per cent of the cost of his or her care. Any person whose income exceeds two hundred per cent of the federal poverty level shall contribute seven per cent of the cost of his or her care in addition to the amount of applied income determined in accordance with the methodology established by the Department of Social Services for

recipients of medical assistance. Any person who does not contribute to the cost of care in accordance with this subdivision shall be ineligible to receive services under this subsection. Notwithstanding [any provision of the general statutes] sections 17b-60 and 17b-61, the department shall not be required to provide an administrative hearing to a person found ineligible for services under this subsection because of a failure to contribute to the cost of care.

(3) Any person who resides in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e and whose income is at or below two hundred per cent of the federal poverty level, shall not be required to contribute to the cost of care. Any person who resides in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e and whose income exceeds two hundred per cent of the federal poverty level, shall contribute to the applied income amount determined in accordance with the methodology established by the Department of Social Services for recipients of medical assistance. Any person whose income exceeds two hundred per cent of the federal poverty level and who does not contribute to the cost of care in accordance with this subdivision shall be ineligible to receive services under this subsection. Notwithstanding [any provision of the general statutes] sections 17b-60 and 17b-61, the department shall not be required to provide an administrative hearing to a person found ineligible for services under this subsection because of a failure to contribute to the cost of care.

(4) The annualized cost of services provided to an individual under the state-funded portion of the program shall not exceed fifty per cent of the weighted average cost of care in nursing homes in the state, except an individual who received services costing in excess of such amount under the Department of Social Services in the fiscal year ending June 30, 1992, may continue to receive such services, provided the annualized cost of such services does not exceed eighty per cent of the weighted average cost of such nursing home care. The commissioner may allow the cost of services provided to an individual

to exceed the maximum cost established pursuant to this subdivision in a case of extreme hardship, as determined by the commissioner, provided in no case shall such cost exceed that of the weighted cost of such nursing home care.

[(j)**]** (k) The Commissioner of Social Services may implement revised criteria for the operation of the program while in the process of adopting such criteria in regulation form, provided the commissioner prints notice of intention to adopt the regulations **[**in the Connecticut Law Journal**]** on the Internet web site of the department and the eRegulations System within twenty days of implementing the policy. Such criteria shall be valid until the time final regulations are effective.

[(k)**]** (l) The commissioner shall notify any access agency or area agency on aging that administers the program when the department sends a redetermination of eligibility form to an individual who is a client of such agency.

[(l)**]** (m) In determining eligibility for the program described in this section, the commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran.

(n) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to (1) define "access agency", (2) implement and administer the Connecticut home-care program for the elderly, (3) implement and administer the presumptive Medicaid eligibility system described in subsection (e) of this section, (4) establish uniform state-wide standards for the program and a uniform assessment tool for use in the screening process, and (5) specify conditions of eligibility.

Sec. 2. Subsection (a) of section 17b-253 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) The Department of Social Services shall seek appropriate

amendments to its Medicaid regulations and state plan to allow protection of resources and income pursuant to section 17b-252. Such protection shall be provided, to the extent approved by the federal Centers for Medicare and Medicaid Services, for any purchaser of a precertified long-term care policy and shall last for the life of the purchaser. Such protection shall be provided under the Medicaid program or its successor program. Any purchaser of a precertified long-term care policy shall be guaranteed coverage under the Medicaid program or its successor program, to the extent the individual meets all applicable eligibility requirements for the Medicaid program or its successor program. Until such time as eligibility requirements are prescribed for Medicaid's successor program, for the purposes of this subsection, the applicable eligibility requirements shall be the Medicaid program's requirements as of the date its successor program was enacted. The Department of Social Services shall count insurance benefit payments toward resource exclusion to the extent such payments (1) are for services paid for by a precertified long-term care policy; (2) are for the lower of the actual charge and the amount paid by the insurance company; (3) are for nursing home care, or formal services delivered to insureds in the community as part of a care plan approved by an access agency approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined in regulations adopted pursuant to subsection **[**(e)**]** (n) of section 17b-342, as amended by this act; and (4) are for services provided after the individual meets the coverage requirements for long-term care benefits established by the Department of Social Services for this program. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection and sections 17b-252, 17b-254 and 38a-475, as amended by this act, relating to determining eligibility of applicants for Medicaid, or its successor program, and the coverage requirements for long-term care benefits.

Sec. 3. Subdivision (1) of subsection (g) of section 17b-354 of the general statutes is repealed and the following is substituted in lieu

thereof (*Effective July 1, 2015*):

(g) (1) A continuing care facility which guarantees life care for its residents, as defined in subsection (b) of this section, (A) shall arrange for a medical assessment to be conducted by an independent physician or an access agency approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined by regulations adopted pursuant to subsection **[**(e)**]** (n) of section 17b-342, as amended by this act, prior to the admission of any resident to the nursing facility and shall document such assessment in the resident's medical file, and (B) may transfer or discharge a resident who has intentionally transferred assets in a sum which will render the resident unable to pay the cost of nursing facility care in accordance with the contract between the resident and the facility.

Sec. 4. Subsection (a) of section 17b-617 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) The Commissioner of Social Services shall, within available appropriations, establish and operate a state-funded pilot program to allow not more than one hundred persons with disabilities (1) who are age eighteen to sixty-four, inclusive, (2) who are inappropriately institutionalized or at risk of inappropriate institutionalization, and (3) whose assets do not exceed the asset limits of the state-funded home care program for the elderly, established pursuant to subsection **[**(i)**]** (j) of section 17b-342, as amended by this act, to be eligible to receive the same services that are provided under the state-funded home care program for the elderly. At the discretion of the Commissioner of Social Services, such persons may also be eligible to receive services that are necessary to meet needs attributable to disabilities in order to allow such persons to avoid institutionalization.

Sec. 5. Section 38a-475 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

The Insurance Department shall only precertify long-term care insurance policies which (1) alert the purchaser to the availability of consumer information and public education provided by the Department on Aging pursuant to section 17b-251; (2) offer the option of home and community-based services in addition to nursing home care; (3) in all home care plans, include case management services delivered by an access agency approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined in regulations adopted pursuant to subsection **[**(e)**]** (n) of section 17b-342, as amended by this act, which services shall include, but need not be limited to, the development of a comprehensive individualized assessment and care plan and, as needed, the coordination of appropriate services and the monitoring of the delivery of such services; (4) provide inflation protection; (5) provide for the keeping of records and an explanation of benefit reports on insurance payments which count toward Medicaid resource exclusion; and (6) provide the management information and reports necessary to document the extent of Medicaid resource protection offered and to evaluate the Connecticut Partnership for Long-Term Care. No policy shall be precertified if it requires prior hospitalization or a prior stay in a nursing home as a condition of providing benefits. The commissioner may adopt regulations, in accordance with chapter 54, to carry out the precertification provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2015*	17b-342
Sec. 2	*July 1, 2015*	17b-253(a)
Sec. 3	*July 1, 2015*	17b-354(g)(1)
Sec. 4	*July 1, 2015*	17b-617(a)
Sec. 5	*July 1, 2015*	38a-475

Statement of Legislative Commissioners:

In Section 1(e)(4)(A), "not later than ninety days after the date the applicant applies for Medicaid coverage" was changed to "not later than ninety days after the date on which home-care services begin" for

accuracy and internal consistency; in Section 1(e)(4)(B), "such applicant shall" was changed to "such applicant is required to" for clarity; at the end of Section 1(e)(4) and in Section 1(f), "presumptive Medicaid eligibility applicants" was changed to "persons determined to be presumptively eligible for Medicaid" for clarity; in Section 1(f) "was completed" was inserted after "Medicaid application" for clarity; in Section 1(h), "how much institutional care would have cost" was changed to "institutional care costs that were averted" for clarity; and in Section 1(n)(3), "described in subsection (e) of this section" was added after "system" for clarity.

AGE *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 16 $	FY 17 $
Social Services, Dept.	GF - See Below	See Below	See Below

Municipal Impact: None

Explanation

This bill requires the Department of Social Services (DSS) to implement presumptive eligibility for the Connecticut Home Care Program (CHCP) under Medicaid. An individual granted presumptive eligibility would receive up to 90 days of care while their eligibility was determined, as well as retroactive coverage for up to 90 days prior to the date the Medicaid application was completed, upon final determination. This would result in several impacts, as detailed below.

First, the state would incur a one-time cost due to the acceleration of eligibility determinations and the provision of benefits sooner. Currently, clients do not receive Medicaid benefits while pending eligibility determinations. The CHCP averaged 203 monthly admissions in FY 14, with a per diem cost of $69. A subset of these clients would experience accelerated eligibility for 90 days.

Second, the state would incur costs for making retroactive payments for individuals determined to be Medicaid eligible. For purposes of an example, making retroactive payments for 57 individuals (the average monthly change in clients) for the three months prior to their application would result in a cost of $359,100. The net cost to the state under Medicaid would be $179,000. This assumes an average monthly cost per enrollee of $2,100; however, it should be noted that an

individual's cost of care prior to entering the program could be higher or lower than the program's average. This also assumes the approval for such payments by the Centers for Medicare and Medicaid Services (CMS).

Third, the state would incur an ongoing cost related to providing benefits for clients who are eventually determined ineligible for Medicaid. It is not known what percentage of CHCP applications are found to be ineligible for Medicaid. For purposes of an example, if it is assumed that the 203 monthly admissions noted above are the result of a 90% eligibility success rate, 20 monthly applications would be found ineligible each month. Therefore, the gross cost of those ineligible clients for 90 days would be approximately $126,000, or a net cost of $63,000.

Lastly, there is a potential savings if the provision of home care services during the eligibility determination process prevents or delays admission to a more expensive, Medicaid funded care setting, such as a nursing home. It cannot be known how many clients may be affected. Although a person is not receiving home care services from the Medicaid program, they may be receiving in-kind care from family members or care paid for from other resources. The average Medicaid cost per day for a nursing home stay is $200. Therefore, for a 90 day episode of care, receiving services under the CHCP rather than a nursing home would result in a savings of approximately $11,800 per person, or $5,900 net.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

Sources: Department of Social Services Caseload Information

OLR Bill Analysis

sSB 860

AN ACT CONCERNING PRESUMPTIVE MEDICAID ELIGIBILITY FOR HOME CARE.

SUMMARY:

This bill requires the social services commissioner, by October 1, 2015, to implement a presumptive eligibility determination program for individuals applying to the Medicaid-funded portion of the Connecticut Home Care Program for Elders (CHCPE). The bill requires the commissioner to adopt regulations to implement and administer the new program.

A presumptive eligibility determination deems an applicant immediately eligible for CHCPE services prior to a full Medicaid-eligibility determination. Under the bill, the state will pay for up to 90 days of care for applicants who (1) require a skilled level of nursing care and (2) are determined presumptively eligible for Medicaid.

The bill also makes minor, technical, and conforming changes.

EFFECTIVE DATE: July 1, 2015

PRESUMPTIVE ELIGIBILITY PROGRAM

Eligibility Determination

By law, the Department of Social Services (DSS) contracts with "access" agencies to determine CHCPE participants' service needs and develop individualized care plans. The bill requires the commissioner to develop a screening tool for these agencies to use to determine if a presumptive eligibility applicant is (1) functionally able to live in a home or community setting ("functionally eligible") and (2) likely to be financially eligible for Medicaid.

If the applicant meets the initial two criteria, the commissioner must authorize the access agency to initiate home care services within five days. DSS must then make (1) a presumptive financial Medicaid-eligibility determination within four days following the functional determination and (2) a final Medicaid-eligibility determination within 45 days of receiving an applicant's completed Medicaid application.

For an individual determined presumptively eligible for Medicaid, the commissioner must, to the extent allowed under federal law, determine the individual retroactively eligible for Medicaid for up to 90 days prior to the date of his or her Medicaid application.

Written Agreement

The bill requires applicants to sign a written agreement attesting to the accuracy of the information they provide. The agreement must also acknowledge that applicants will (1) receive state-funded services within 90 days after the home-care services begin and (2) complete a Medicaid application on the day they are screened for functional eligibility or within 10 days after.

REPORTING REQUIREMENTS

By law, the commissioner must report certain CHCPE information to the Human Services Committee. The bill adds to this information the:

1. number of persons determined presumptively eligible for Medicaid,

2. savings for the state based on institutional care costs that were averted by correctly determining individuals presumptively eligible, and

3. the number of persons incorrectly determined presumptively eligible and the costs to provide them with home care services before the final eligibility determination.

The bill also defines the estimated savings, which the commissioner

must also report, as estimated savings to provide home care versus institutional care for all program participants.

REGULATIONS

The bill allows the commissioner to implement the program while in the process of adopting regulations, as long as he publishes notice of his intention to adopt them on the department's web site and the Secretary of State's online eRegulations system. Under prior law, such notice had to be printed in the *Connecticut Law Journal.*

BACKGROUND

Program Description

CHCPE is a Medicaid waiver and state-funded program that provides home- and community-based services for eligible individuals age 65 and older who are institutionalized or at risk of institutionalization.

Related Bill

HB 6397, reported favorably by the Aging Committee, provides for up to three months of retroactive assistance for Medicaid-eligible services to CHCPE participants.

COMMITTEE ACTION

Aging Committee

Joint Favorable
Yea 13 Nay 0 (03/05/2015)